NATIONAL SCIENCE FOUNDATION - POLAR PHYSICAL EXAMINATION (ANTARCTICA)

# MEDICAL HISTORY

Complete pages 1-5 in ink prior to Dr.'s exam

**Polar Medical Staff Use Only**

Reviewed/Date: _____

**Polar Medical Staff Use Only**

☐ PQ ☐ PQ Summer Only ☐ NPQ

Medical Conditions:

_____

_____

Restrictions and Follow-up:

_____

_____

Reason for NPQ:_____

| Name: last, first, middle (must match passport) | Birth date _____ (YY/MM/DD) | Telephone (include area code) |
|---|---|---|
| Street City State Zip | | Day: Evening: |

| Age | Sex ☐ F ☐ M | Nickname | E-Mail: |
|---|---|---|---|

Emergency Point of Contact (Name, Address and Phone Number):

| **Affiliation:** | **Affiliation:** | **Proposed Antarctic Season**: | **Proposed Antarctic Worksite:** |
|---|---|---|---|
| ☐ NSF | ☐ RPSC Job Title:_____ _____ | ☐ Summer (Aug-Feb) | ☐ McMurdo Station |
| ☐ Science Event #_____ | | ☐ Winter (Mar-Oct) | ☐ Field Camp |
| ☐ Official Visitor Event #_____ | ☐ Other Contractor Job Title:_____ _____ | ☐ Other _____ (dates) | ☐ South Pole Station |
| ☐ Technical Event #_____ | | | ☐ Palmer Station |
| | | | ☐ RV/NB Palmer |
| | | | ☐ RV/LM Gould |
| | | | ☐ USCG Icebreaker |
| | | | ☐ Other (specify)_____ |

| Estimated Deployment Dates | Previous Polar (Arctic or Antarctic) Deployment? |
|---|---|
| From _____ to _____ | Date: _____ Location: _____ |

**FAMILY PERSONAL MEDICAL HISTORY******DO NOT USE FOR YOUR OWN HEALTH HISTORY****

| Relationship | Age | Status of Health, if living | Age and Cause of Death |
|---|---|---|---|
| Father | | | |
| Mother | | | |
| Spouse | | | |
| Brothers/Sisters/ Children (list below): | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

| Family History of: Check box, If yes, who? (explain): | | | Relationship | Family History of: Check box, If yes, who? (explain): | | | Relationship |
|---|---|---|---|---|---|---|---|
| Diabetes? Insulin Required? | ☐ YES ☐ YES | ☐ NO ☐ NO | | Kidney Disease? Describe: | ☐ YES | ☐ NO | |
| Heart Attack? Age? _____ | ☐ YES | ☐ NO | | Cancer? Type? | ☐ YES | ☐ NO | |
| Stroke? Age? _____ | ☐ YES | ☐ NO | | | | | |
| Bleeding Disorder? Describe: (Hemophilia, Clotting Factor Deficiency)_____ | ☐ YES | ☐ NO | | Stomach/GI Disease? Type? _____ _____ | ☐ YES | ☐ NO | |
| Autoimmune Disorder? Describe: (Rheumatoid Arthritis, Lupus, Other) _____ | ☐ YES | ☐ NO | | Mental Health Disorders? Describe: (i.e., Depression, Bipolar, Suicide, Schizophrenia) _____ _____ | ☐ YES | ☐ NO | |
| Hemoglobin disorder? Describe: (Sickle Cell, Thalassemia, etc.) _____ | ☐ YES | ☐ NO | | | | | |

NAME_____ DOB _____

**PERSONAL MEDICAL HISTORY (ANSWER THE FOLLOWING QUESTIONS REGARDING YOUR PRESENT OR PAST MEDICAL HISTORY)**

**Do you have any allergies to medications**? ☐ YES ☐ NO If yes, which?

**Do you have any other known allergies**? ☐ YES ☐ NO If yes, describe (including your reaction).

Medications**:** List all you take, including Over-the-Counter Medications and Vitamins:

| Name of Medication | Dose | How Often Taken – daily, twice daily, as needed, etc. |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Surgeries/Hospitalizations –** List all surgeries and dates (include any outpatient surgery): If more space is needed, use back or add a sheet.

| | | | | **ADDITIONAL COMMENTS** |
|---|---|---|---|---|
| 1 | **Seizure disorder**?<br>Date of Last Seizure:_____ | ☐ YES | ☐ NO | |
| | **Head Injury?**<br>Loss of Consciousness – Date_____<br>How Long_____ | ☐ YES | ☐ NO | |
| 2 | **Headaches**? | ☐ YES | ☐ NO | |
| | **Migraines**?<br>Date Diagnosed_____<br>Date of last Migraine_____ | ☐ YES | ☐ NO | |
| 3 | **Vision**: Do you wear ☐ glasses? ☐ contacts? | ☐ YES | ☐ NO | |
| | Do you have unequal pupils? | ☐ YES | ☐ NO | |
| | Do you have blindness in one or both eyes? | ☐ YES | ☐ NO | |
| | Do you have Glaucoma? | ☐ YES | ☐ NO | |
| | Do you have Cataracts | ☐ YES | ☐ NO | |
| | Do you have Double Vision? | ☐ YES | ☐ NO | |
| | Do you have other vision problems?<br>Describe: | ☐ YES | ☐ NO | |
| 4 | **Dizziness/Fainting**<br>Reason:<br>Date of occurrence:_____ | ☐ YES | ☐ NO | |
| 5 | **Do you have ear, nose, or throat problems?**<br>Describe: | ☐ YES | ☐ NO | |
| | **Hearing Impairment?** | ☐ YES | ☐ NO | |
| | **Hayfever?** | ☐ YES | ☐ NO | |
| | Are you currently taking allergy shots? | ☐ YES | ☐ NO | |

NAME_____ DOB _____

**PERSONAL MEDICAL HISTORY (continued)**

| ANSWER THE FOLLOWING QUESTIONS REGARDING YOUR PRESENT OR PAST MEDICAL HISTORY | | | ADDITIONAL COMMENTS |
|---|---|---|---|
| 6 **Do you have any Pulmonary Disease?** | ☐ YES | ☐ NO | |
| **Chronic Obstructive Pulmonary Disease (COPD)?** | ☐ YES | ☐ NO | |
| **Pulmonary Embolism/Blood Clots?** | ☐ YES | ☐ NO | |
| **Sleep Apnea?** | ☐ YES | ☐ NO | |
| **Asthma?**<br>Date of last attack_____<br>Number of attacks in past year_____ | ☐ YES | ☐ NO | |
| **Emphysema or chronic Bronchitis or Bronchiectasis?** | ☐ YES | ☐ NO | |
| **Shortness of Breath of Difficult Breathing?**<br>Explain: | ☐ YES | ☐ NO | |
| **Tuberculosis** | ☐ YES | ☐ NO | |
| History of positive TB skin test | ☐ YES | ☐ NO | |
| Have you ever received BCG? | ☐ YES | ☐ NO | |
| **Have you ever experienced altitude sickness?**<br>At what altitude_____<br>Describe treatment: | ☐ YES | ☐ NO | |
| 7 **Do you have Heart Problems/Disease?** | ☐ YES | ☐ NO | |
| **Previous Heart Attack?** | ☐ YES | ☐ NO | |
| **Angina/Chest Pain?**<br>Describe (include frequency, precipitating factors, and treatments): | ☐ YES | ☐ NO | |
| **Congestive Heart Failure (CHF)?** | ☐ YES | ☐ NO | |
| **Supraventricular Tachycardia (SVT)?**<br>Date diagnosed_____<br>Frequency and treatment: | ☐ YES | ☐ NO | |
| **Atrial Fibrillation?**<br>Date diagnosed_____ | ☐ YES | ☐ NO | |
| **Heart Murmur/Valvular Heart Disease?**<br>Date diagnosed_____<br>Limitations: | ☐ YES | ☐ NO | |
| ☐**Angiogram** ☐**Angioplasty** ☐**Stent**<br>☐**Cardiac Bypass Surgery**<br>Date_____ | ☐ YES | ☐ NO | |
| **Pacemaker?** | ☐ YES | ☐ NO | |
| **Hypertension?**<br>Date diagnosed_____ | ☐ YES | ☐ NO | |
| **TIA/Stroke?**<br>Date _____ | ☐ YES | ☐ NO | |
| **History of Deep Vein Thrombosis (DVT)/Blood Clots?** | ☐ YES | ☐ NO | |
| **History of Abdominal or Cerebral Aneurysm?** | ☐ YES | ☐ NO | |
| 8 **Do you have diabetes**?<br>Date diagnosed:_____<br>Controlled by: ☐Insulin ☐Oral medication ☐Diet<br>Last Emergency Room visit:_____ | ☐ YES | ☐ NO | |
| 9 **Do you have Cholesterol disorders?**<br>Date diagnosed:_____<br>Controlled by: ☐Oral medication ☐Diet | ☐ YES | ☐ NO | |
| 10 **Arthritis?**<br>Type: _____ | ☐ YES | ☐ NO | |
| Permanent disability? | ☐ YES | ☐ NO | |

NAME_____ DOB _____

**PERSONAL MEDICAL HISTORY (continued)**

| ANSWER THE FOLLOWING QUESTIONS REGARDING YOUR PRESENT OR PAST MEDICAL HISTORY | | | ADDITIONAL COMMENTS |
|---|---|---|---|
| 11 **Do you have Gout?**<br>If so, describe your treatment plan | ☐ YES | ☐ NO | |
| 12 **Do you have Thyroid Disease?**<br>Explain, if Yes - include medication | ☐ YES | ☐ NO | |
| Surgery required?<br>When?_____ | ☐ YES | ☐ NO | |
| 13 **Have you ever used tobacco/tobacco products?** | ☐ YES | ☐ NO | |
| **Do you currently use tobacco/tobacco products?**<br>Type of use ☐cigarettes ☐cigar ☐pipe ☐chew<br>Packs per week? _____<br>Number of years of tobacco use in past _____<br>If you've quit, last year of use_____ | ☐ YES | ☐ NO | |
| 14 **Have you had an Exercise Stress Test/Treadmill?**<br>If yes, when?_____ | ☐ YES | ☐ NO | |
| 15 **Do you have a regular exercise program?**<br>Describe: | ☐ YES | ☐ NO | |
| 16 **Have you had Stomach/Bowel Problems?** | ☐ YES | ☐ NO | |
| Anemia | ☐ YES | ☐ NO | |
| Black tarry stools | ☐ YES | ☐ NO | |
| Blood in stools | ☐ YES | ☐ NO | |
| Frequent or persistent diarrhea | ☐ YES | ☐ NO | |
| Gallbladder Problems/Stones | ☐ YES | ☐ NO | |
| Heartburn | ☐ YES | ☐ NO | |
| Hemorrhoids | ☐ YES | ☐ NO | |
| Inflammatory bowel disease (Crohns/Ulcerative Colitis) | ☐ YES | ☐ NO | |
| Ulcers | ☐ YES | ☐ NO | |
| Date of last flare up_____ | | | |
| 17 **Have you been diagnosed with liver problems?** | ☐ YES | ☐ NO | |
| **Hepatitis?** | ☐ YES | ☐ NO | |
| Type ☐A ☐B ☐C ☐Other | | | |
| 18 **Do you have Kidney problems?** | ☐ YES | ☐ NO | |
| History of Kidney Stones? | ☐ YES | ☐ NO | |
| Polycystic Kidney Disease? | ☐ YES | ☐ NO | |
| Frequent Urinary Tract Infections? | ☐ YES | ☐ NO | |
| 19 **Do you have a history of Hernias?**<br>Date_____<br>Location_____ | ☐ YES | ☐ NO | |
| 20 **Have you had any sexually transmitted diseases?** | ☐ YES | ☐ NO | |
| When? _____<br>Type: ☐Herpes ☐Chlamydia ☐Gonorrhea<br>☐Syphillis ☐Other Specify)_____ | | | |
| Treated?<br>When? _____<br>Describe: | ☐ YES | ☐ NO | |
| 21 **Cancer or leukemia?** | ☐ YES | ☐ NO | |
| Type/Location:_____ | | | |
| Date diagnosed_____ | | | |
| Surgery | ☐ YES | ☐ NO | |
| Chemotherapy | ☐ YES | ☐ NO | |
| Radiation Therapy | ☐ YES | ☐ NO | |
| Other Treatment:_____ | ☐ YES | ☐ NO | |

NAME_____ DOB _____

**PERSONAL MEDICAL HISTORY (continued)**

| ANSWER THE FOLLOWING QUESTIONS REGARDING YOUR PRESENT OR PAST MEDICAL HISTORY | | | ADDITIONAL COMMENTS |
|---|---|---|---|
| 22 **Skin rash/Disease?**<br>Describe (include duration and treatment): | ☐ YES | ☐ NO | |
| 23 **Broken bones?**<br>Orthopedic Pins/Plates?<br>Dislocations?<br>Back injuries<br>For any "YES" answers, list date, area affected and treatment: | ☐ YES<br>☐ YES<br>☐ YES<br>☐ YES | ☐ NO<br>☐ NO<br>☐ NO<br>☐ NO | |
| 24 **Have you ever been or are you currently treated for?**<br>☐Schizophrenia ☐Depression ☐Bipolar ☐ Panic Attacks<br>☐Anxiety Attacks ☐Obsessive/Compulsive Disorder<br>☐Suicide Attempt/Thoughts ☐Eating Disorders<br>☐Addiction ☐Other:_____<br>**Have you ever been hospitalized for psychiatric treatment**?<br>Describe with length and dates: | ☐ YES<br>☐ YES | ☐ NO<br>☐ NO | |
| 25 **For Men**:<br>History of Prostate disease including prostatitis or prostate stones?<br>When? Describe treatment:<br>Surgery required?<br>Date_____ | ☐ YES<br>☐ YES<br>☐ YES | ☐ NO<br>☐ NO<br>☐ NO<br>☐ NO | |
| 26 **For Women**:<br>Date of last period: _____<br>Date of last PAP Smear: _____<br>Results: ☐ Normal ☐ Other (describe):<br>Are you currently taking Oral contraceptives?<br>History of severe Menstrual Cramps/PMS?<br>Endometriosis?<br>Ovarian Cysts?<br>Describe treatment: | ☐ YES<br>☐ YES<br>☐ YES<br>☐ YES | ☐ NO<br>☐ NO<br>☐ NO<br>☐ NO | |
| 27 **Do you drink alcohol**?<br>Quantity per day_____ Total per week_____<br>Have you ever felt you should decrease your drinking?<br>Explain:<br>Have you ever received a DUI or court ordered treatment?<br>Describe circumstances:<br>Have you ever been diagnosed as an alcoholic?<br>If now sober, length of sobriety_____ | ☐ YES<br>☐ YES<br>☐ YES<br>☐ YES | ☐ NO<br>☐ NO<br>☐ NO<br>☐ NO | |

**I certify that the information contained herein is complete and accurate to the best of my knowledge. I will inform the contractor's medical staff of <u>ALL</u> medical/health changes that occur after submitting this form. I understand that failure to provide any or all of the requested information may result in a denial of my application for assignment to the Polar Regions. I also understand that willfully providing false statements to a Federal agency or its representatives is a criminal offense.**

_____ _____ _____

Print Name Signature Date